Idaho Infant Toddler Program
Data-Tot Entry Form September 2008

Child's Information:

Name (last, first, initial) _____

Male Female (circle one) DAR ID (DDIS)# _____

Child's Date of Birth (DOB) _____/_____/_____ Child's SS # _____

Biological Mother's DOB _____/_____/_____ Mother's SS# _____

Biological Father's DOB _____/_____/_____ Father's SS# _____

****

Child's Race (Check one): __ Asian __ Black ___ Hispanic ___Native American ___White ___ Other _____ (SPECIFY)

Premature birth? Y N IF "YES" : Gestational age: _____ weeks

Family's Primary Language: _____ **Child's Physician:** _____

Purpose for Form

- ☐ Intake (Referral)
- ☐ Enrollment (IFSP)
- ☐ Update ___/___/___
- ☐ 6-Month Review ___/___/___
- ☐ Annual Review / /

Caregiver's Information:

(Primary)

Name (last, first) _____ **Relationship** _____ (Specify)

Phone (day) _____ (night) _____ (message) _____

Address (mail) _____ Schl. Dist._____

City _____ State _____ Zip_____ County _____

(Secondary)

Name (last, first) _____ **Relationship** _____ (Specify)

Phone (day) _____ (night) _____ (message) _____

Address (mail) _____ Schl. Dist._____

City _____ State _____ Zip_____ County _____

Comments: _____

_____

_____

Referral Information:

Date of Referral: ____/____/____ **45 Days:** ____/____/____

Re-Open: ____/____/____

Re-Open Comments: _____

_____

Referral Source:

- ☐ 1 Hospital
- ☐ 2 Physician
- ☐ 3 Parent/Friend/Other
- ☐ 4 Child Care Program
- ☐ 5 Local Ed. Agency
- ☐ 6 Public Health Facility
- ☐ 7 Other Social Service Agency
- ☐ 8 Other Health Care Provider

Referred By: _____ (List Hospital, Agency, Caseworker, and/or Doctor's name)

Reason for Referral: (Area of Concern / General Information) _____

_____

_____

_____

Form Completion:

Today's Date: ____/____/____

Form Completed by:

_____

Contact Phone: _____

CC:_____

Please return this form to:

_____

IFSP Information:

Original IFSP Date ____/____/____

IFSP completed in 45 days? Y N

If No, Reason: Family / Agency (circle one)

Please explain_____

_____

Eligibility for ITP:

____ Established Condition

____ Developmental Delay

____ Informed Clinical Opinion

If ICO, date of team review ____/____/____

Co-Enrollment:

(Circle)

Currently involved with CFS? Y N

If yes: Substantiated / Unsubstantiated

Currently enrolled in ISDB? Y N

Previously monitored (ASQ)? Y N

Newborn hearing screened? Y N

Family homeless at entry? Y N

All initial parental consents Y N

All initial PWN's Y N

Payment Source(s):

(Number 1 for primary, 2 for secondary)

____ Medicaid #_____

____ Private Insurance

____ Part C

____ Other (Specify) _____

Primary Service Setting:

____ Typical Child Program

____ EI Center

____ Home

____ Hospital (Inpatient)

____ Residential Facility

____ Service Provider's Location

____ Other _____

If child is ≥ 30 months old:

Date LEA Notified or Opt-Out Selected:

(If opted-out, enter 9/9/99) ____/____/____

If child is ≥ 33 months old:

Transition Meeting Date:

____/____/____

	Service Category and/or Evaluations	Date of Eval	Eligible for Services Y or N	Provider (Name)	Provider (Agency)	* Service Setting (Use codes below)	* Service Type (G- Group or I - Individual)	Projected Hours on IFSP (per 6 month) # Contacts	** Start Date identified on IFSP or Addendum	** Actual Date Service Began	Service End Date
1	Service Coordination										
2	Assistive Technology										
3	**Audiological Services**										
4	**Developmental Therapy**										
5	Family Training										
6	Health Services										
7	Medical Services (diagnostic/eval)										
8	Nursing										
9	Nutrition										
10	**Occupational Therapy**										
11	**Physical Therapy**										
12	**Psychological Services**										
13	Respite Care										
14	**Social Work Services**										
15	**Speech/Language Therapy**										
16	Transportation										
17	Vision services										
18	Other										
19	Other										
20	Other										

***Service Setting/Type Codes:** *(must include Location AND Type)*.

Location:

TYP- Typical EIC- EI Center RES- Residential
HOM- Home HOS- Hospital SPL - Serv. Provider Loc.
OTH- *Other: (please explain)* _____

Explain justification for EACH **Service Setting** listed above that is not delivered in the **Typical** or **Home** environment:

_____

****If **Actual Date Service Began** was later than **Start Date identified on IFSP or Addendum**, identify the **Service Category** row number (SVC CAT), circle reason, and explain.**

SVC CAT _____ Family / Agency / Neither _____

SVC CAT _____ Family / Agency / Neither _____

SVC CAT _____ Family / Agency / Neither _____

Idaho Infant Toddler Program Data-Tot Entry Form – Page 2

___ Enrollment ___ Update

Child's Name: _____ **DOB:** _____

Service Coordinator: _____ **Today's Date:** _____

Condition Information

Start Date	End Date	Condition Code (ITP)	*Med Dx (ICD-9)*	*Ed Dx (ICD-9)*	Description

Exit Information

Exit Reason: (Check appropriate box – only one) **Exit Date** _____/_____/_____

- ☐ 1 - Met IFSP goals prior to age 3 (graduated).
- ☐ 2- Part B Eligible.
  If so, still served by ITP (summer transition)? Y N
- ☐ 3- Part B Ineligible, exit to other program.
- ☐ 4- Part B Ineligible, exit with no referral.
- ☐ 5- Part B eligibility undetermined.
  If so, was this due to documented parent request? Y N
- ☐ 6- Deceased.
- ☐ 7- Moved out of state.
- ☐ 8- Withdrawn by parent/guardian.
  Transferred to another Region? Y N
  (If YES, to Region_____).
  If not transferred, please explain:
  _____
  _____
- ☐ 9- Attempts to contact parent/guardian unsuccessful.
  Explain:
  _____
  _____
- ☐ 10- Intake Only.
  Explain:
  _____
  _____

Child Outcomes Summary

Entry

Outcome	**Rating**	***Notes***
Positive Social Emotional Skills:	_____	_____
Acquiring and Using Knowledge and Skills:	_____	_____
Taking Appropriate Action to Meet Needs:	_____	_____

Completed by: _____ ***Date:*** _____

Exit

Outcome	**Rating**	**Made Progress?**	***Notes***
Positive Social Emotional Skills:	_____	Y N	_____
Acquiring and Using Knowledge and Skills:	_____	Y N	_____
Taking Appropriate Action to Meet Needs:	_____	Y N	_____

Completed by: _____ ***Date:*** _____